

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0021436</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Lewis Memorial Christian Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2002</u> to <u>June 30, 2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>3400 West Washington</u> <u>Springfield</u> <u>62707</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Sangamon</u>			
<b>Telephone Number:</b> <u>217-787-9600</u> <b>Fax #</b> <u>217-787-9601</u>			
<b>IDPA ID Number:</b> <u>51-0173104001</u>			
<b>Date of Initial License for Current Owners:</b> <u>09/1977</u>			
<b>Type of Ownership:</b>		<b>Officer or Administrator of Provider</b>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Signed) _____ (Date) _____	
<input checked="" type="checkbox"/> Charitable Corp.		(Type or Print Name) <u>Mark Havrilka</u>	
<input type="checkbox"/> Trust		(Title) <u>Chief Financial Officer</u>	
<b>IRS Exemption Code</b> <u>501c3</u>		(Signed) _____ (Date) _____	
<input type="checkbox"/> PROPRIETARY		<b>Paid Preparer</b>	
<input type="checkbox"/> Individual		(Print Name and Title) <u>William O. Buskirk</u> <u>CPA</u>	
<input type="checkbox"/> Partnership		(Firm Name & Address) <u>Eck, Schafer &amp; Punke LLP</u> <u>600 East Adams Springfield, IL 62701-1624</u>	
<input type="checkbox"/> Corporation		(Telephone) <u>217-525-1111</u> <b>Fax #</b> <u>217-525-1120</u>	
<input type="checkbox"/> "Sub-S" Corp.		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b>	
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>William O. Buskirk</u> <b>Telephone Number:</b> <u>217-525-1111</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Lewis Memorial Christian Village# 0021436 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>76</u>	Skilled (SNF)	<u>76</u>	<u>27,740</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>79</u>	Intermediate (ICF)	<u>79</u>	<u>28,835</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>155</u>	TOTALS	<u>155</u>	<u>56,575</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,092</u>	<u>11,000</u>	<u>2,548</u>	<u>26,640</u>	8
9	SNF/PED					9
10	ICF	<u>10,494</u>	<u>17,292</u>		<u>27,786</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,586</u>	<u>28,292</u>	<u>2,548</u>	<u>54,426</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 96.20%

D. How many bed-hold days during this year were paid by Public Aid?

94 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 09/19/1977

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 38 and days of care provided 2,548Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2003 Fiscal Year: 06/30/2003

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	288,351	31,972	12,786	333,109		333,109		333,109		1
2	Food Purchase		267,754		267,754		267,754	(555)	267,199		2
3	Housekeeping	250,773	35,746		286,519		286,519		286,519		3
4	Laundry							(715)	(715)		4
5	Heat and Other Utilities			142,650	142,650		142,650	6,220	148,870		5
6	Maintenance	100,781	7,304	47,386	155,471		155,471	11,565	167,036		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	639,905	342,776	202,822	1,185,503		1,185,503	16,515	1,202,018		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,000	1,000		1,000		1,000		9
10	Nursing and Medical Records	2,390,323	187,917	11,204	2,589,444		2,589,444	(7)	2,589,437		10
10a	Therapy			290,465	290,465		290,465		290,465		10a
11	Activities	45,648			45,648		45,648		45,648		11
12	Social Services	91,929	4,986	6,859	103,774		103,774	(2,238)	101,536		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,527,900	192,903	309,528	3,030,331		3,030,331	(2,245)	3,028,086		16
	<b>C. General Administration</b>										
17	Administrative	138,950		286,206	425,156		425,156	(211,866)	213,290		17
18	Directors Fees										18
19	Professional Services			15,739	15,739		15,739	9,890	25,629		19
20	Dues, Fees, Subscriptions & Promotions			17,698	17,698		17,698	(2,820)	14,878		20
21	Clerical & General Office Expenses	83,926	8,316	76,209	168,451		168,451	58,952	227,403		21
22	Employee Benefits & Payroll Taxes			592,801	592,801		592,801	27,491	620,292		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,351	14,351		14,351	9,370	23,721		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			85,761	85,761		85,761	4,130	89,891		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	222,876	8,316	1,088,765	1,319,957		1,319,957	(104,853)	1,215,104		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,390,681	543,995	1,601,115	5,535,791		5,535,791	(90,583)	5,445,208		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name &amp; ID Number

Lewis Memorial Christian Village

#0021436

Report Period Beginning:

July 1, 2002

Ending:

June 30, 2003

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			153,841	153,841		153,841	20,701	174,542			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			112,577	112,577		112,577	(49,856)	62,721			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							(1,290)	(1,290)			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>Deferred Bond Costs</b>			1,933	1,933		1,933	(147)	1,786			36
37	<b>TOTAL Ownership</b>			268,351	268,351		268,351	(30,592)	237,759			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			4,756	4,756		4,756		4,756			39
40	Barber and Beauty Shops	31,695	2,168		33,863		33,863		33,863			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):* <b>Apt/Congregate</b>			857,581	857,581		857,581		857,581			43
44	<b>TOTAL Special Cost Centers</b>	31,695	2,168	947,200	981,063		981,063		981,063			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,422,376	546,163	2,816,666	6,785,205		6,785,205	(121,175)	6,664,030			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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Facility Name &amp; ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

July 1, 2002

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## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(555)	2		4
5	Telephone, TV & Radio in Resident Rooms	(704)	5		5
6	Rented Facility Space	(1,290)	34		6
7	Sale of Supplies to Non-Patients	(7)	10		7
8	Laundry for Non-Patients	(715)	4		8
9	Non-Straightline Depreciation	3,519	30		9
10	Interest and Other Investment Income	(77,362)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,529)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,215)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	11,976			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (98,882)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(22,293)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (22,293)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (121,175)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Lewis Memorial Christian VillageID# 0021436Report Period Beginning: July 1, 2002Ending: June 30, 2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ (2,238)	12	1
2	Activity	1,939	21	2
3	Loss on Equipment Disposal	656	21	3
4	Miscellaneous Income	(147)	36	4
5	Marketing Expense	(5,925)	21	5
6	Exempt Interest Income - Endowment	27,506	32	6
7	Survey Fine	(6,995)	17	7
8	Non deductible dues - Lobbying Expense - IHCA	(2,820)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	11,976		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

July 1, 2002

Ending:

June 30, 2003

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(555)	0	0	0	0	0	0	0	0	0	0	(555)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(715)	0	0	0	0	0	0	0	0	0	0	(715)	4
5	Heat and Other Utilities	(704)	6,924	0	0	0	0	0	0	0	0	0	6,220	5
6	Maintenance	0	11,565	0	0	0	0	0	0	0	0	0	11,565	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,974)</b>	<b>18,489</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16,515</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(7)	0	0	0	0	0	0	0	0	0	0	(7)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(2,238)	0	0	0	0	0	0	0	0	0	0	(2,238)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(2,245)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,245)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(6,995)	(204,871)	0	0	0	0	0	0	0	0	0	(211,866)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,890	0	0	0	0	0	0	0	0	0	9,890	19
20	Fees, Subscriptions & Promotions	(2,820)	0	0	0	0	0	0	0	0	0	0	(2,820)	20
21	Clerical & General Office Expenses	(37,074)	96,026	0	0	0	0	0	0	0	0	0	58,952	21
22	Employee Benefits & Payroll Taxes	0	27,491	0	0	0	0	0	0	0	0	0	27,491	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,370	0	0	0	0	0	0	0	0	0	9,370	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,130	0	0	0	0	0	0	0	0	0	4,130	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(46,889)</b>	<b>(57,964)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(104,853)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(51,108)</b>	<b>(39,475)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(90,583)</b>	<b>29</b>



Facility Name & ID Number Lewis Memorial Christian Village# 0021436Report Period Beginning: July 1, 2002 Ending: June 30, 2003

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Christian Homes Inc	100.00%	\$ 6,924	\$ 6,924 1
2	V	6 Maintenance				11,565	11,565 2
3	V	17 Administrative	270,168			65,297	(204,871) 3
4	V	18 Directors					
5	V	19 Professional Services				9,890	9,890 5
6	V	20 Fees, Subscriptions					
7	V	21 Clerical				96,026	96,026 7
8	V	22 Employee Benefits				27,491	27,491 8
9	V	23 Inservice Training					
10	V	24 Travel & Seminar				9,370	9,370 10
11	V	26 Insurance				4,130	4,130 11
12	V	30 Depreciation				17,182	17,182 12
13	V						
14	Total		\$ 270,168			\$ 247,875	\$ * (22,293) 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

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Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	This workpaper is not applicable.					Hours	Percent	Description	Amount		1
2									\$		2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lewis Memorial Christian Village# 0021436

Report Period Beginning:

July 1, 2002Ending: ne 30, 2003

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<a href="#">This workpaper is not applicable.</a>				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	Financing Fee						\$	\$			\$ 600	1
2	CIB Mortgage		x	Refinance Bldg & Equip	\$12,266.00	05/01/02	1,920,000	1,879,358	04/01/07	0.0583	111,977	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$12,266.00		\$ 1,920,000	\$ 1,879,358			\$ 112,577	9
	B. Non-Facility Related*											
10	Revenue Bonds 2001-Y		x	Refinance	\$2,771.00	10/01/01	475,000	475,000	10/01/31	0.0700	33,250	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				\$2,771.00		\$ 475,000	\$ 475,000			\$ 33,250	14
15	TOTALS (line 9+line14)						\$ 2,395,000	\$ 2,354,358			\$ 145,827	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Lewis Memorial Christian Village**# **0021436** Report Period Beginning: **July 1, 2002** Ending: **June 30, 2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2002 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	N/A 2
3. Under or (over) accrual (line 2 minus line 1).			\$	#VALUE! 3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	#VALUE! 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	8		
	1999	9		
	2000	10		
	2001	11		
	2002	12		
			<b>FOR OHF USE ONLY</b>	
			13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    Lewis Memorial Christian Village    COUNTY    Sangamon

FACILITY IDPH LICENSE NUMBER    0021436

CONTACT PERSON REGARDING THIS REPORT    Brenda Lavin

TELEPHONE    217-732-9651    FAX #:    217-732-8686

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>See Attached List</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		<b>TOTALS</b>	\$ <u></u>	\$ <u></u>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?     YES    X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A.

Square Feet:

55,000

B. General Construction Type:

Exterior

Masonry

Frame

Steel

Number of Stories

1

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments

Congregate

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

None

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	217,800	Various	\$ 308,762	1
2	Home Office Allocation			9,293	2
3	TOTALS	217,800		\$ 318,055	3

Facility Name &amp; ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

July 1, 2002 Ending: June 30, 2003

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155			1977	\$ 2,286,830	\$ 56,166	40	\$ 57,171	\$ 1,005	\$ 1,450,901	4
5				1978	100,542		40	2,514	2,514		5
6				1979	420,937		20				6
7											7
8		Home Office Allocation			67,023	1,927		1,927		34,614	8
		Improvement Type**									
9		Bldg Improvement		1979	306	6	38	6		144	9
10		Bldg Improvement		1981	4,662	155	30	155		3,385	10
11		Heating/Cooling Systems		1981	20,153		20			20,153	11
12		Exhaust Fan		1983	417		15			417	12
13		Door Assembly		1985	1,244	62	20	62		1,116	13
14		Bldg Improvement		1986	573	29	20	29		498	14
15		Pass-thru WD		1986	664	33	20	33		547	15
16		Remodeling		1987	800	40	20	40		653	16
17		Rooftop Compressor		1988	3,408		10			3,408	17
18		Air System		1989	1,090	55	20	55		793	18
19		A/C Unit		1989	4,406		8			4,406	19
20		Remodeling		1989	6,193	310	20	310		4,443	20
21		Tile, Cover Base		1989	6,600		5			6,600	21
22		Wall Paper		1989	826		5			826	22
23		Cabinets		1990	100		15			100	23
24		Roof Top A/C Unit		1991	4,158		10			4,158	24
25		Command Moduole		1991	1,318		5			1,318	25
26		Wall Paper/Carpet		1991	14,848		5			14,848	26
27		Drapery Hardware		1991	1,124		5			1,124	27
28		Carpeting		1992	640		5			640	28
29		Curtain Track		1992	523		5			523	29
30		Curtain Track		1992	4,124		5			4,124	30
31		Receptacle		1992	575		10			575	31
32		Curtain Track		1992	565		5			565	32
33		Curtain Track		1992	1,229		5			1,229	33
34		Door Control		1993	722	20	15	20		476	34
35		Nurse Station Remodel		1993	30,556	1,528	20	1,528		14,913	35
36		Wallcoverings		1993	751		5			751	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

July 1, 2002 Ending: June 30, 2003

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Wallcoverings	1994	\$ 3,747	\$	5	\$	\$	\$ 3,747		37
38	A/C Compressors	1994	1,506	151	10	151		1,497		38
39	Exhaust Fans	1994	2,183	146	15	146		1,448		39
40	Roof Entire Building	1993	125,670	8,378	15	8,378		80,747		40
41	Downspout Repairs	1994	6,000	400	15	400		3,800		41
42	Ceiling Tile	1994	1,149	115	10	115		1,083		42
43	Wallpaper/Floor Covering	1994	20,655		5			20,655		43
44	Lounge Remodel	1995	14,653		5			14,653		44
45	Volunteer Room Expansion	1995	8,435	843	10	843		6,078		45
46	Remodel Wing 100	1995	44,657	1,922	10	1,922		41,295		46
47	Remodel Shower Wing	1995	23,023	2,302	5	2,302		18,992		47
48	Wallcovering	1995	35,194		5			35,194		48
49	Stainless Steel Floor Cooler	1996	1,873		5			1,873		49
50	Wanderguard Alzheimer	1996	10,455	1,046	10	1,046		7,419		50
51	Wallcovering	1996	3,910		5			3,910		51
52	Wallcovering	1996	22,106		5			22,106		52
53	Gas Meter & Lines	1997	7,378		5			7,378		53
54	Maglocks & Keypad	1997	7,194	719	10	719		4,554		54
55	Nurse Call System	1997	9,727	973	10	973		6,159		55
56	Wallcovering	1997	28,134	185	5	185		28,134		56
57	Exhaust Fan	1997	12,370	1,237	10	1,237		7,319		57
58	Upgrade Energy Management System	1997	14,513	1,451	10	1,451		8,585		58
59	Upgrade Antennae System	1997	2,400	80	5	80		2,400		59
60	Wallcoverings - 400 Wing	1997	21,389		10			21,389		60
61	Wallcovering	1997	6,836	571	5	571		6,836		61
62	Fire Safety Gas Valve	1998	617	63	5	63		617		62
63	Locks	1998	782	93	5	93		782		63
64	Wiring for Network	1998	625	94	5	94		625		64
65	Outlets for Kronos	1998	664	133	5	133		632		65
66	Entrance Canopy	1998	3,667	733	5	733		3,360		66
67	Fire Alarm Control Panel	1998	28,154	2,815	10	2,815		12,902		67
68	Repl Fire Alarm Device	1999	4,800	480	10	480		2,120		68
69	Kitchen Hood	1999	6,910	691	10	691		2,994		69
70	TOTAL (lines 4 thru 69)		\$ 3,469,283	\$ 85,952		\$ 89,471	\$ 3,519	\$ 1,959,531		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,469,283	\$ 85,952		\$ 89,471	\$ 3,519	\$ 1,959,531	1
2	Fire Alarm Devices	1999	4,600	460	10	460		1,993	2
3	Replace 8 Shower Valves	2000	10,084	2,017	5	2,017		7,732	3
4	Panduit Raceway	2000	13,130	1,313	10	1,313		4,924	4
5	Kitchen Ceiling	2000	5,923	592	10	592		1,973	5
6	Kitchen Walls	2000	2,099	210	10	210		648	6
7	CARPET #207	2000	1,344	269	5	269		785	7
8	WATER HEATERS	2001	37,299	3,730	10	3,730		8,703	8
9	NATURAL GAS REGULATOR	2001	1,184	118	10	118		275	9
10	40 GALLON WATER HEATER	2001	506	51	10	51		106	10
11	Remodel Shower-Wing 200	1/21/2002	3,500	350	10	350		525	11
12	(2) Horton Single Swing Security Door	3/28/2002	4,094	273	15	273		364	12
13	Rooftop A/C-Heat Unit	1/15/2002	3,762	251	15	251		377	13
14	Carpet Installation-TV Lounge & 2 Dwavs	5/30/2002	1,787	357	5	357		417	14
15	Heating/AC Unit	4/15/2002	1,348	90	15	90		113	15
16	Replacement of Heat/AC Unit Pump	4/30/2002	1,449	97	15	97		121	16
17	(3) Touch Security Lock Systems	9/6/2002	4,599	383	10	383		383	17
18	Install New Door Closers - 300 Wing	11/1/2002	13,990	622	15	622		622	18
19	Burglar Alarm Equipment	12/12/2002	2,896	169	10	169		169	19
20	Repair Fire Alarm System - 2 Detectors	6/5/2003	639	5	10	5		5	20
21	Shelving for Walk-In Cooler	6/30/2003	1,154	5	20	5		5	21
22	AC Compressor - Copeland	6/30/2003	1,295	9	12	9		9	22
23	Fully Depreciated land improvements	6/30/1978	167,005		20			167,005	23
24	Landscaping	9/30/1984	6,077	304	20	304		5,700	24
25	Landscaping	10/21/1985	1,852	93	20	93		1,651	25
26	Landscaping and drainage	9/30/1986	8,436	422	20	422		7,074	26
27	Fire hydrant	8/1/1987	6,849	342	20	342		5,461	27
28	Land improvements	6/28/1993	1,564	147	10	147		1,564	28
29	Landscape courtyard	6/10/1998	5,134	940	5	940		5,134	29
30	Concrete pad for dumpster	5/28/2002	5,134	342	15	342		399	30
31	Asphalt patch & crack seal	7/11/2002	4,104	513	8	513		513	31
32	Asphalt repaving	6/5/2003	5,033	52	8	52		52	32
33	10 x 8 Shelter	11/29/1995	3,700	370	10	370		863	33
34	TOTAL (lines 1 thru 33)		\$ 3,800,853	\$ 100,848		\$ 104,367	\$ 3,519	\$ 2,185,196	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,800,853	\$ 100,848		\$ 104,367	\$ 3,519	\$ 2,185,196	1
2	Garage	1/1/1999	44,246	1,106	40	1,106		39,269	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15	Less: Disposals		(20,875)					(20,629)	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,824,224	\$ 101,954		\$ 105,473	\$ 3,519	\$ 2,203,836	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 471,704	\$ 51,818	\$ 51,818	\$	Various	\$ 249,034	71
72	Current Year Purchases	43,075	1,996	1,996		Various	1,996	72
73	Fully Depreciated Assets	432,042				Various	432,042	73
74	Home Office Allocation	116,318	12,315	12,315			64,399	74
75	TOTALS	\$ 1,063,139	\$ 66,129	\$ 66,129	\$		\$ 747,471	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1989 Ford Bus	1989	\$ 38,359	\$	\$	\$	8	\$ 38,359	76
77	Patient Transportation	1993 Chevy PU w/blade	1998	13,290				3	13,290	77
78										78
79	Home Office Allocation			13,401	2,940	2,940			6,150	79
80	TOTALS			\$ 65,050	\$ 2,940	\$ 2,940	\$		\$ 57,799	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,270,468	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 171,023	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,542	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,519	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,009,106	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment bldg, land impr & equip	\$ 4,485,413	\$ 129,127	\$ 1,666,530	86
87	Congregate bldg, land impr & equip	3,477,621	84,562	1,156,581	87
88	Wellness Center bldg & equip	665,888	17,415	50,741	88
89					89
90					90
91	TOTALS	\$ 8,628,922	\$ 231,104	\$ 2,873,852	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 15,478	92
93			93
94			94
95		\$ 15,478	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**Ending: June 30, 2003**

**A. Building and Fixed Equipment (See instructions.)**

**If NO, see instructions.**

☐ NO

**10. Effective dates of current rental agreement:**

## Ending

Fiscal Year Ending	Annual Rent
--------------------	-------------



11

✻

☐ **YES**☐ NO

**Description:**

**(Attach a schedule detailing the breakdown of movable equipment)**

\* If there is an option to buy the building, please provide complete details on attached schedule.

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

D. NUMBER OF AIDES TRAINED

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
2	Licensed Speech and Language Development Therapist	This workpaper is not applicable.	hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 938,721	\$	1
2	Cash-Patient Deposits	18,510		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 79,831 )	855,230		3
4	Supply Inventory (priced at FIFO )	28,330		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Acc Int Rec/Other A/R</u>	16,816		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,857,607	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	308,762		13
14	Buildings, at Historical Cost	11,400,076		14
15	Leasehold Improvements, at Historical Cost	713,804		15
16	Equipment, at Historical Cost	1,270,713		16
17	Accumulated Depreciation (book methods)	(5,745,514)		17
18	Deferred Charges	46,595		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,754,430		21
22	Other Long-Term Assets (spe CIP )	15,478		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 10,764,344	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 12,621,951	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 558,905	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,510		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	340,136		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,323		32
33	Accrued Interest Payable	9,123		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,016,997	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,879,358		40
41	Bonds Payable	475,000		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due Apt. Residents</u>	2,093,707		43
44	<u>Deferred apartment income</u>	1,401,935		44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 5,850,000	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 6,866,997	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 5,754,954	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 12,621,951	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>5,582,474</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>5,582,474</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>772,480</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>772,480</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Transfer Out to Affiliate</b>	<b>(600,000)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(600,000)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>5,754,954</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 7,168,110	1
2	Discounts and Allowances for all Levels	(1,267,313)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,900,797	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	456,505	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 456,505	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	42,563	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	555	14
15	Telephone, Television and Radio	704	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	7	18
19	Laboratory	4,888	19
20	Radiology and X-Ray	7,636	20
21	Other Medical Services	1,975	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 58,328	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	96,407	24
25	Interest and Other Investment Income***	77,362	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 173,769	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Unrealized G(L) on Investments/Sale of Equip</b>	(330)	28
28a	<b>Residential/Congregate</b>	968,616	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 968,286	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,557,685	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,185,503	31
32	Health Care	3,030,331	32
33	General Administration	1,319,957	33
	<b>B. Capital Expense</b>		
34	Ownership	268,351	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	896,200	35
36	Provider Participation Fee	84,863	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,785,205	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	772,480	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 772,480	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lewis Memorial Christian Village# 0021436Report Period Beginning: July 1, 2002Ending: June 30, 2003

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,830	1,863	\$ 53,091	\$ 28.50	1
2	Assistant Director of Nursing	1,829	1,862	44,249	23.76	2
3	Registered Nurses	9,596	9,766	233,398	23.90	3
4	Licensed Practical Nurses	34,571	34,746	653,658	18.81	4
5	Nurse Aides & Orderlies	111,201	112,626	1,343,095	11.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,721	5,796	62,832	10.84	8
9	Activity Director	1,955	2,041	20,542	10.06	9
10	Activity Assistants	1,762	1,826	25,106	13.75	10
11	Social Service Workers	7,858	8,163	91,929	11.26	11
12	Dietician					12
13	Food Service Supervisor	1,638	1,666	25,951	15.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,275	25,551	262,400	10.27	15
16	Dishwashers					16
17	Maintenance Workers	6,662	6,766	100,781	14.90	17
18	Housekeepers	23,146	23,358	250,773	10.74	18
19	Laundry					19
20	Administrator	3,625	3,711	138,950	37.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,825	1,867	33,570	17.98	23
24	Clerical	4,276	4,374	50,356	11.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Beauty Shop</u>	2,136	2,198	31,695	14.42	33
34	TOTAL (lines 1 - 33)	244,906	248,180	\$ 3,422,376 *	\$ 13.79	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	284	\$ 12,786	1.3	35
36	Medical Director	12	1,000	9.3	36
37	Medical Records Consultant	48	2,740	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	52	2,400	10.3	39
40	Physical Therapy Consultant	1,777	116,715	10A.3	40
41	Occupational Therapy Consultant	1,655	106,473	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,010	67,277	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	75	6,006	12.3	45
46	Other(specify) <u>Dental</u>	18	1,825	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,931	\$ 317,222		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	Description	Amount	
Robert Florence	Administrator	0	\$ 95,249	Workers' Compensation Insurance	\$ 104,688	IDPH License Fee	\$			
John Fidler	Administrator	0	43,701	Unemployment Compensation Insurance	45,720	Advertising: Employee Recruitment			1,801	
				FICA Taxes	250,108	Health Care Worker Background Check (Indicate # of checks performed _____)				
				Employee Health Insurance	172,500	IHCA Dues			8,273	
				Employee Meals		Subscription dues & licenses			1,973	
				Illinois Municipal Retirement Fund (IMRF)*		Internet & Media Fees			34	
				Employee Expense	13,229	Software upgrades & support			4,422	
				Employee Physicals	7,296	Miscellaneous			1,195	
				Employee Uniforms	(740)	Non deductible			(2,820)	
						Less: Public Relations Expense	(			
						Non-allowable advertising	(			
						Yellow page advertising	(			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 138,950					TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,878	
B. Administrative - Other										
Description			Amount							
Management Fee			\$ 270,168	Home Office Allocation	27,491					
Other administrative expenses			16,038							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 286,206	TOTAL (agree to Schedule V, line 22, col.8)	\$ 620,292					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount		
Helen Pyle	Nurse Consultant		\$ 552				Out-of-State Travel	\$ 6,209		
Management Resource Solutions	Referral Fee		5,540							
Pinnacle Consulting	Consultant		500							
Donald L Casper PC	Consultant		223				In-State Travel	2,948		
FR & R Healthcare	Consultant		300							
McNamara & Evans	Legal		758							
Van Ostrand	Legal		3,290							
Davis & Campbell	Legal		4,326				Seminar Expense	3,378		
Clinical Radiologists	Consultant		250				Miscellaneous travel and seminar	1,816		
							Home office allocation	9,370		
							Entertainment Expense	(		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 15,739	TOTAL		\$	(agree to Sch. V, line 24, col. 8)			
							TOTAL	\$	23,721	

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)**

[illegible]

Facility Name & ID Number Lewis Memorial Christian Village

STATE OF ILLINOIS

# 0021436

Report Period Beginning: July 1, 2002

Page 23

Ending: June 30, 200

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA - \$8,273
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,052 Line 3.10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 84,863  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? x If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 555
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Eck, Schafer & Punke LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. It will be provided upon completion.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

## 6/30/2003

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	Benefit Percentage	Employee Uniforms	Employee Expense	Employee Physicals	
175,082.49	30,996.00	70,968.00	132,000.00					
21,805.24	4,260.00	9,768.00	2,250.00	7,849.31				
18,777.63	4,332.00	9,924.00	375.00	9,287.47				639,740.51
7,223.83	1,380.00	3,144.00	4,500.00	5,926.16				
9,939.46	2,436.00	5,580.00	10,125.00	6,441.59				
14,936.26	1,836.00	4,200.00	18,750.00	16,472.03	-740.05	13,228.65	7,296.00	
2,343.26	480.00	1,104.00	4,500.00	963.18				
250,108.17	45,720.00	104,688.00	172,500.00	46,939.74	-740.05	13,228.65	7,296.00	639,740.51
Less Benefits:								46,939.74
Line 3.22.3								592,800.77